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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JULIE LYNN GARCIA** **16714 Janine Drive** **Whittier, CA 90603** **Registered Nurse License No. 648448** Respondent.	Case No. 2013-929 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On or about November 22, 2004, the Board issued Registered Nurse License Number 648448 to Julie Lynn Garcia (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2014, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 2811(b) of the Code provides, in pertinent part, that the Board may renew an expired license at any time.

STATUTORY PROVISIONS

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

". . . ."

8. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with

Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

". . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. Code section 4060 states:

"No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer. Nothing in this section authorizes a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices."

REGULATIONS

10. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

11. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

12. California Code of Regulations, title 16, section 1443.5, states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

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COSTS

13. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

DRUG

14. **Hydromorphone**, also known by the trade name **Dilaudid**, is a schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(J), and is a dangerous drug pursuant to Code section 4022.

FACTUAL ALLEGATIONS

15. At all times mentioned herein, Respondent was employed as a registered nurse in the Emergency Department of Saint Jude Medical Center located in Fullerton, California (SJMC).

16. An internal investigation at SJMC revealed that between December 4, 2010 and December 5, 2010, Respondent made inaccurate entries in patient medical records, took at least 2 mg of her patients' medications, and delayed administering her patient's medications, as follows:

a. Patient A: On December 4, 2010, the physician ordered 2 mg Hydromorphone at 1717 hours, 1753 hours, 1907 hours, and 2006 hours. On December 4, 2010, at 1716 hours, Respondent withdrew 2 mg of Hydromorphone (Dilaudid) for this patient from the Pyxis,[1] and documented on the Medication Administrative Record (MAR) that it was administered at 1745 hours. At 1751, a different registered nurse withdrew 2 mg of Hydromorphone for patient A, and documented on the MAR that it was administered at 1801. At 1904, Respondent withdrew 2 mg Dilaudid, and documented on the MAR that it was admnistered at 1911. At 1909 hours,

[1] "Pyxis" is a trade name for the automatic single-unit dose medication dispensing system that records information such as patient name, physician orders, date and time medication was withdrawn, and the name of the licensed individual who withdrew and administered the medication. Each user/operator is given a user identification code to operate the control panel. Sometimes only portions of the withdrawn narcotics are given to the patient. The portions not given to the patient are referred to as "wastage." This waste must be witnessed by another authorized user and is also recorded by the Pyxis machine.

Respondent withdrew 2 mg Dilaudid for this patient with override. At 1911 hours, Respondent cancelled 2 mg Dilaudid for this patient with override, and the MAR indicates that it was not administered. At 2100, Respondent withdrew 2 mg Dilaudid, and there is no indication on the MAR that it was administered. There is no record of wastage. In summary, there are 2 mg of Dilaudid missing.

b. Patient B: On December 4, 2010, the physician ordered 1 mg Hydromorphone at 1957 hours. The Pyxis report indicates that at 2058 hours on December 4, 2010, Respondent withdrew 2 mg Dilaudid from the Pyxis, and wasted 1 mg of that same drug at the same time. The wasted medication was witnessed by another registered nurse. Respondent documented on the MAR that she administered Dilaudid 1 mg at 2227 hours. In summary, all controlled substances are accounted for, however, there is a two hour discrepancy between the time Respondent withdrew the Dilaudid from the Pyxis, and when she documented that she administed it.

c. Patient C: On December 4, 2010, the physician ordered 4 mg Hydromorphone at 2320 hours. The Pyxis report indicates that at 2346 hours, Respondent withdrew 4 mg Dilaudid. Respondent documented on the MAR that on December 4, 2010, she administered the medication at 0012 hours on December 5, 2010. In summary, all medication is accounted for, however, there is a 26 minute discrepancy between the time Respondent withdrew the Dilaudid from the Pyxis, and when she documented that she administered it.

d. Patient D: On December 5, 2010, the physician ordered 1 mg Hydromorphone at 1401 hours, and 1539 hours. The Pyxis report indicates that Respondent withdrew 2 mg of Dilaudid from the Pyxis at 1501 hours, and wasted 1 mg of Dilaudid at that time. The wasted medication was witnessed by another registered nurse. Respondent documented on the MAR that she administered 1 mg Dilaudid at 1516 hours. The MAR also indicates that she administered another 1 mg of Dilaudid to this patient at 1600 hours. There is no Pyxis record indicating that Respondent withdrew a second dose of Dilaudid for this patient at that time. Respondent offered no explanation for this documentation discrepancy to the Board's investigator. There is no evidence in the record that Respondent conducted a follow-up assessment including reassessment of pain, or measurement of vital signs, after the administration of Dilaudid. In summary,

Respondent documented that she administered 1 mg Dilaudid that she never withdrew from the Pyxis.

e. Patient F: On December 5, 2010, the physician ordered 1 mg Hydromorphone at 1927 hours, 2013 hours, and 2059 hours. The Pyxis record reflects that another registered nurse withdrew 2 mg at 1936 hours for patient F, and wasted 1 mg. Another registered nurse documented on the MAR that she administered 1 mg Dilaudid for patient F at 1940. Respondent withdrew 2 mg. of Dilaudid at 2022 hours for patient F, and then wasted 1 mg Dilaudid, with a witness present. Respondent documented on the MAR that she administered 0.5 mg of Dilaudid "by request of [the patient]" on December 5, 2010 at 2015 hours. There is 0.5 mg of Dilaudid missing, and not accounted for in the records. The Pyxis record reflects that another registered nurse then withdrew 2 mg Dilaudid for patient F at 2113 hours, and Respondent witnessed her waste 1 mg. Another registered nurse documented that she administered 1 mg Dilaudid to patient F at 2112. In summary, there is 0.5 mg of Dilaudid missing.

g. Patient G: On December 5, 2010, the physician ordered Hydromorphone at 2306 hours. The Pyxis record reflects that Respondent withdrew 2 mg of Dilaudid using an override at 2310 hours, and that she wasted 1 mg of the drug at the same time, without a witness present. Respondent documented on the MAR that she administered 1 mg of Dilaudid to this patient at 2315 hours. However, the Emergency Room record indicates that the patient was discharged from treatment at 2220 hours. In her interview with the Board's investigator, Respondent stated that she had estimated the times the patient was discharged when she completed the MAR documentation. The Pyxis record, however, cannot be estimated. Respondent failed to accurately account for the controlled substance in the hospital record. In summary, Respondent removed 2 mg of Dilaudid from the Pyxis, recorded that she wasted 1 mg – without any witness present – and then recorded that she administered 1 mg to the patient almost an hour after the patient was discharged from treatment.

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FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - (False Entries in Hospital/Patient Records)

17. Respondent is subject to disciplinary action under section 2761(a), on the grounds of unprofessional conduct, as defined in Code section 2762(e), in that between on or about December 4, 2010 and December 5, 2010, while on duty as a registered nurse at SJMC, in Fullerton, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital, patient, or other records pertaining to the controlled substance Hydromorphone also known as Dilaudid, as is detailed in paragraphs 15 through 16, above, which are incorporated herein by reference.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence/Incompetence)

18. Respondent is subject to disciplinary action under section 2761(a), on the grounds of unprofessional conduct, as defined in Code section 2761(a)(1), in that between on or about December 4, 2010 and December 5, 2010, while on duty as a registered nurse at SJMC, Respondent engaged in gross negligence and/or incompetence as detailed in paragraphs 15 through 16, above, which are incorporated here by this reference.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Unlawfully Obtaining/Possessing and/or Administering Dangerous Drugs)

19. Respondent is subject to disciplinary action under section 2761(a), on the grounds of unprofessional conduct, as defined in Code section 2762(a), in that between on or about December 4, 2010 and December 5, 2010, while on duty as a registered nurse at SJMC, Respondent illegally obtained, possessed, and/or administered a dangerous drug, Hydromorphone also known as Dilaudid, as detailed in paragraphs 15 through 16, above, which are incorporated here by this reference.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 648448 issued to Julie Lynn Garcia

2. Ordering Julie Lynn Garcia to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: April 18, 2013

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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